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| MND PLAN | MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | (X2) ML A. BUIL B. WIN | DING: | DATE SURVEY COMPLETED |
|--------------------------|---|---|------------------------------------|--|--|
| VALUE ONE | ROVIDER OR SUPPLIER | HFD12-0837 | ـ الــــــــــــــــــــــــــــــ | · · · · · · · · · · · · · · · · · · · | 05/03/2007 |
| invide Ot 1 | KOVIDEK OK SUPPLIER | | | Y, STATE, ZIP GODE | DOIOGIZOUT |
| SYMBRA | ·. · | WASHIN | AILTON ST IGTON, DC | NW 20011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDE 3'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFE TENCED TO THE APPROPR DEFICIENCY) | DG - |
| 1 000 | INITIAL COMMEN | is . | 1:000 | | |
| | selected from a res males with various the survey were bar | was conducted on May 3, ampling of two residents was idential population of three disabilities. The findings of sed on observations, lents and staff in the home as | 1 | | |
| | records, including in | esident and administrative icident reports, | | | |
| | 3504.1 HOUSEKEE | | 1 090 | LUU I MAY | A HEA |
| act au | maintained in a saft and sanitary manne | erior of each GHMRP shall be a, clean, orderly, attractive, r and be free of t, rubbish, and objectionable | | AT 28 A | REGELVE RIMENT OF LITH REGUL DMINISTRAT |
| j.;:] | based on observatio | net as evidenced by: | , | \$ 6 | HEALTH ION |
| [1 | esidential facility wa | is found to be out of section as identified below: | | | 36 34 |
| t | l. Cracked and miss pathroom sink. | ing caulking around first floor | | The cracked and missing caulking around first floor bathroom sink has been repaired. | 5/31/2007 |
| 2 | . Base of dining tab | le was loose. | | Dining room table base was repaired. | 5/04/2007 |
| 1 | . Tom backdoor sc | ~ 1 | | Tom back door screen has been repaired. | 5/31/2007 |
| | . Backyard cement | | | Backyard cernent pavement has been repaired. | 6/15/2007 |
| ł | | eackyard porch light. | • | Globe has been installed on back yard porch light. | 5/31/2007 |
| 6 | . Paint peeling on st oor | airs leading from the back | | The stairs leading from the back door has been repainted. | 6/15/2007 |
| 7. bi | Cable wire hanging uilding and over a from Administration | l loose from the back of the | · | The cable has been removed from the tree branch in the backyard. | 5/25/2007 |

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HEALTH REGULATION ADMIN

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| ATEMEN ID PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDENSUPPLIE IDENTIFICATION NUI | R/CLIA MBER | (X2) MUL A. BUILD B. WING | The state of the s | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|------------------------|---------------------------------------|--|---------------------------------------|------------------------|
| WENED | ROVIDER OR SUPPLIER | HFD12-0037 | | | | 05/0 | 3/2007 |
| YMBRA | | | 133 HAM | ILTON ST, STON, DC | , STATE, ZIP CODE NW 20011 | · · · · · · · · · · · · · · · · · · · | |
| (X4) ID PREFIX TAG | EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | C111 t | ID PREEIX TAG | PROVIDE ?'S PLAN OF COR (EACH CONRECTIVE ACTION GROSS-REFE RENCED TO THE A DEFICIENCY) | SHOULDAR | (XS) COMPLE DATE |
| 1 090 | Continued From pa | ge 1 | 1 | 1 090 | | r e | |
| | 8. Paint peeling on and back of the buil | all window sills in the ding. | front | | The front and back windows ha scraped And repainted. | ve been | 6/15/20 |
| | 9. Chair with torn c #3's bedroom | ushion in Resident# | 2 and | · | The damaged chair has been rem bedroom a difference chair put it | oved from the 1 its place. | 5/31/20 |
| | | Sushion on the front p | : | | The chair has been removed from porch. | n the front | 5/04/20 |
| , | | n basement celling li sement bathroom ce | | ti t i, | The light fixture in the basement replaced. | area has been | 5/31/20 |
| | exposing wires. | 4 · 4 | | | The hole in the basement bathro repaired. | om has been | 5/31/20 |
| | 13. Paint pealing on door. | stairs leading to the | front | -1 | The steps leading to the from do- painted. | or has béen | 6/15/20 |
| | 14. Unused freezer | | rs, | | The unused freezer has been ren the dining room. | | 6/15/20 |
| | 15. Broken lawn mo limbs and wrought in storage building. | wer, wooden crates, on rack in back of the | iree 9 | | Bulk trash has been contacted ar to remove the unused freezer, bro mower and other items by 6/15/2 | oken lawn | 6/1:5/20 |
| | 3, 2007 at approxima | administrative staff ately 7:00PM reveale of the dining room, lav | d that | - 1 - 1 | Staff were inserviced on 5/16/10 | manager and | ; :- • |
| - } | mower, wooden craft | es, tree limbs and wr he storage building w | pught | | administration, Manager will momentally basis. Maintenance and monitor quarterly to ensure comp | OA will | |
| 1135 | 3505.5 FIRE SAFET | Υ , , , , , | | 1135 | | | i |
| i.a | Each GHMRP shall to order to test the effer four (4) times a year | conduct simulated fin ctiveness of the plan for each shift. | edrills in at least | · · · · · · · · · · · · · · · · · · · | | | 14 |
| | This Statute is not m Based on staff interv | net as evidenced by: | | | v | | : |

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If continuation sheet 2 of 10

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| STATEMEN AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0037 | (X2) MUI A. BUILD B. WING | | (XS) DATE S COMPLI | |
|--------------------------|--|--|---------------------------------|--|-----------------------|-----------------------------|
| NAME OF F | ROVIDER OR SUPPLIER | | DDRESS CITY | , STATE, ZIP CODE | | 3/2007 |
| SYMBRA | IL. | 133 HAI | MILTON ST, IGTON, DC | NW | | |
| (X4) ID PREFIX TAG | IEACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCHENTIFYING INFORMATION) | PREFIX TAG | PROVIDE TS PLAN OF COM (EACH CORRECTIVE ACTION CROSS REFE LENCED TO THE DEFICIENCY) | SHOW D'AF | (XS): COMPLETE DATE |
| I 135 | all shifts. The finding include | evacuation drills quarterly on | J135 | The staff were inserviced on 5/2 concerning completed a fire dri Manager and QA will monitor a basis to ensure compliance. | Il on each shift. | 5/31/2007 and ongoing |
| , K. | from July, 2006, to approximately 1:001 was conducted on t Further review reve conducted on the ev quarter. There was | able fire drill records dated April, 2007 on May 3, 2007 at PAPIL, 2007 on May 3, | | | . <u>-</u> | ag. |
| 1206 | 3509 6 PERSONNE | L POLICIES | 1.206 | 195 | ည်းက မို ဒ ဗ | |
| ľ | annually thereafter, certification that a hi performed and that | or to employment and shall provide a physician 's salth inventory has been the employee 's health status ter to perform the required | | | et 2, 1 | |
| | · | | | | | |
| | Based on record rev | net as evidenced by: lew, the facility failed to nad current health certificates | | , 19 | | , n |
| •], | The finding includes | • • • |). | · . | : | ak |
| | approximately 4:45 f evidence of current i staff members. In a | nel records on May 3, 2007 at PM revealed no documented realth certificates for two n interview with the Qualified Professional (QMRP) on May ately 6:50PM it was | | 7 | | |

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If continuation sheet 3 of 10

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD 12-0037 | ERICLIA: IMBER: ** | (X3) B A BUILDING B. WING | | | 3) DATE SURVEY COMPLETED 05/03/2007 | |
|--------------------------|--|---|--|--|---|--|---|--|
| NAME OF P | ROVIDER OR SUPPLIER | * | 133 HAM | DRESS CITY, ILTON ST. I STON, DC | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCE MUST BE PRECEDED BY SCIDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| 1 229 | Professional and the May 3, 2007 at app the staff had not returned to the twelve months in the staff had not return the months in the staff had not be staff ha | s: Qualified Mental Retaile review of training to poximately 5:50PM received training within | records on evealed | 1229 | Staff were inserviced on Nu and Sexuality on 2/5/07. A schedule for 6/11/2007. The will monitor training record basis to ensure that staff rectraining. | addition training is the Manager and QA I on a quarterly | 6/15/2007 and ongoing | |
| 1332 | At admission or co secure for each res Individual Habilitati | ON POLICIES PROC mmitment, each GH ident an on Plan, which is de C. Code § 6-1943 (1 | MRP shall | 1 332 | The DDS case manager has the need to complete the Is 1. Symbral will request DE ISP of any future admission days of admittance if a cumprovided. | SP for consumer # OS to complete the a with thirty (30) | 6/15/2007 and ongoing, | |
| | This Statute is not Based on interview felled to failed to er residents in the sau Plan (ISP). (Reside The finding include Interview with the 1-2007 at approximal Resident #1 did not interview revealed developed by Resident verification. | s: louse Manager on M lety 9:55AM revealed thave an ISP. Furth that the ISP was beli lent #1's case mana revealed that Reside d was admitted to th | the facility two al Support fay 3, d that her ng ent#1 did | er er | | | | |

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HEALTH REGULATION ADMIN

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| REGULATORY OR LSC IDENTIFYING INFORMATION) 1 379 Continued From page 5 1 379 Staff have been inserviced on policy and procedure concerning accidents/ injuries on and | | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-6037 | (X2) MUL A. BUILDI B. WING | | (X3) DATE SU COMPLE 05/03 | |
|--|------------|---|--|----------------------------------|---|--|-----------------------------|
| WASHINGTON, DC 20014 PROVIDENCE MUST BE PRECEDED BY TOUR PROVIDENCE PLAN OF CORRECTION PRINCIPLY TAND PROVIDENCE PLAN OF CORRECTION PROVIDENCE PLAN OF CORRECTION COMMENTATION PRICE PLAN OF CORRECTION COMMENTATION COMMENTATION | NAME OF PI | ROVIDER OR SUPPLIER | | ET ADDRESS, CITY | STATE ZIF CODE | <i>y</i> | |
| TAG 1 379 Continued From page 5 1 379 3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Besed on interview and record review the facility falled to ensure that the Department of Health (DOH) was notified of any unusual incident which substantially interferes with a resident's Health for one of two residents in the sample. (Resident #1) The finding includes: Review of an incident report dated April 9, 2007 on May 3, 2007 at approximately 10.25PM indicated that Resident's twas taken to an emergency room (ER) after falling at his day program and sustaining a laceration on the corner of his digit eye. Interview with the House Manager on May 3, 2007 at approximately 12:30PM revealed this unusual incident was not forwarded to the DOH. There was no evidence that the DOH was notified regarding this unusual incident. | SYMBRA | Ľ | | | | • a | <i>3</i> 4 |
| 1379 3619.10 EMERGENCIES In addition to the reporting requirement in 3519.5 each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare living arrangement, well being or in any other way places the resident at resident and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure that the Department of Health (DOH) was notified of any anusal incident which substantially interfers with a resident's health for one of two residents in the sample. (Resident #1) The finding includes: Review of an incident report dated April 9, 2007 on May 3, 2007 at approximately 10:25PM indicated that Resident #1 was taken to an emergency room (ER) after failing at his day program and sustaining a laceration on the corner of his right eys. Interview with the House Manager on May 3, 2007 at approximately 12:30PM revealed this unusal incident. 1391 3520.2(a) PROFESSION SERVICES: GENERAL 1391 | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | (EACH COF RECTIVE ACTI CROSS-REFERENCED TO TO | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| This Statute is not met as evidenced by. Based on interview and record review the facility falled to ensure that the Department of Health (DOH) was notifed of any unusal incident which substantially interfers with a resident's health for one of two residents in the sample. (Resident #1) The finding includes: Review of an incident report dated April 9, 2007 on May 3, 2007 at approximately 10:25PM indicated that Resident #1 was taken to an emergency room (ER) after failing at his day program and sustaining a laceration on the corner of his right eye. Interview with the House Manager on May 3, 2007 at approximately 12:30PM revealed this unusal incident was not forwarded to the DOH. There was no evidence that the DOH was notified regarding this unusal incident. 1391 3520.2(a) PROFESSION SERVICES: GENERAL | l: | In addition to the research GHMRP shall Health, Health Facunusual incident or interferes with a rearrangement, well places the resident be made by teleph followed up by writer | Porting requirement in 351 inotify the Department of littles Division of any other event which substantially sident 's health, welfare, it being or in any other way at risk. Such notification some immediately and shall ten notification within | 1,379 (9.5, ving | procedure concerning accide 5/16/2007. Staff have been in communicate to nursing all a occur in and outside of the haschool, community. DOH will events that significantly affect welfare and living arrangement review consumers' records of | nts/injuries on instructed to accidents that come i.e work, il be notified of the health, out. QA will | 5/16/2007 and ongoing |
| Review of an incident report dated April 9, 2007 on May 3, 2007 at approximately 10:25PM indicated that Resident #1 was taken to an emergency room (ER) after falling at his day program and sustaining a laceration on the corner of his right eye. Interview with the House Manager on May 3, 2007 at approximately 12:30PM revealed this unusal incident was not forwarded to the DOH. There was no evidence that the DOH was notified regarding this unusal incident. 1391 3520.2(a) PROFESSION SERVICES: GENERAL 1391 | i i | This Statute is not Based on Interview falled to ensure that (DOH) was notifed substantially interfer | met as evidenced by: and record review the fac at the Department of Health of any unusal incident whi ars with a resident's health | n ch Jor | | N ST | |
| | | Review of an incide on May 3, 2007 at indicated that Resi emergency room (program and susta corner of his right Manager on May 3 12:30PM revealed forwarded to the D that the DOH was | ant report deted April 9, 20 approximately 10:25PM dent #1 was taken to an ER) after falling at his day aning a laceration on the eye. Interview with the Hou 2007 at approximately this unusal incident was no | use ot: ce | | | |
| | 1391 | 3520.2(a) PROFES | SSION SERVICES: GENE | RAL 1391 | , p | | |

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HEALTH RECULATION ADMIN

2010/014

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| | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0037 | (X2) MULT A BUILDII B. WING | · · · · · · · · · · · · · · · · · · · | (X3) DATE SURVEY COMPLETED 05/03/2007 |
|--------------------------|--|---|-----------------------------------|--|--|
| NAME OF P | ROVIDER OR SUPPLIER | | | STATE, ZIP CODE | , m |
| SYMBRA | XL , | MASHING | ILTON ST, I STON, DC : | W 20011 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ESCIDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDERS PLAN OF CORRE (EACH COF RECTIVE ACTION SH CROSS REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETE |
| 1 391 | necessary profession accordance with the individual habilitation necessary by the improfessional service limited to, those se trained, qualified, a District of Columbia disciplines or areas (a) Medicine; This Statute is not based on record returned to provide the failed to provide | o carry out and monitor onal interventions, in e goals and objectives of every on plan, as determined to be sterdisciplinary team. The es may include, but not be rvices provided by individuals at licensed as required by | 1.391 | The Manager has been inserviced emergency/ follow-up care protoc Director of Nursing and CEO will copy of a emergency medical condischarge orders immediately verticity of the report within (24) how completion. The Residential Director a check-list form on a weel ensure that any emergency follow monitor for completion in a timely monitor to ensure compliance on basis for the next six months and quarterly thereafter. | ol. The receive a sultation/ eally and a ars of ctor will kly basis to -up is y. QA will a monthly |
| | #1) The finding include | | | | |
| | on May 3, 2007 at Indicated that Residence from (I program and sustancement of his right of the commendation for the days. Review May 3, 2007 at approximately 3. | or Resident #1 to be evaluated a Physician (PCP) in two to w of the medical record on proximately 3:15 PM revealed idence that the PCP evaluated | | | |
| 1.395 | 3520.2(e) PROFES | SSION SERVICES: GENERAL | 1395 | | |
| | Each GHMRP sha | l have avallable qualified | | <u> </u> | |

Health Regulation Administration

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"TEXALEM RESERVANTUM EXPONERS

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| Heam F | <u>Reg⊔lation Administr</u> | ation | e de Caraño, de Caraño Caraño, de Caraño, de C | real section is a section of the sec | | ** * * ********* |
|--|---|--|---|--|---|-----------------------------|
| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MOU A. BUILDI B. WING | · | (X3) DATE SU COMPLE | |
| <u> </u> | | HFD12-0037 | 2 (6.3) (1.0) (4.3) | | 05/03 | 1/2007 |
| NAME OF F | ROVIDER OR SUPPLIER. | | | STATE, ZIP CODE | | |
| SYMBRA | ŅĻ. | 133 WAS | Hamilton'st, Hington, DC | NW 2001:1 | ge regul | 14 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC.IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH COFRECTIVE ACTION SHI CROSS-REFE RENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 1.395 | Continued From pa | ge 7 | 1395 | | | |
| , , | necessary professi accordance with the individual habilitation necessary by the in | carry out and monitor onal interventions, in a goals and objectives of e in plan, as determined to b terdisciplinary team. The as may include, but not be | very: | | | |
| | limited to, those se trained, qualified, a District of Columbia disciplines or greas | vices provided by individuand licensed as required by a law in the following | als : | | | er . |
| : | (e) Nursing: | | | 1 | , | |
| S. P. S. | Based on record re ensure nursing sen | met as evidenced by: view the facility failed to rices (Resident #2) | | | | - ; :- |
| | The findings include | >: | | ** | | _ |
| | 1, 2007 on May 3, 2 AM revealed that R Lipitor 20 mg, by m | ysician's orders dated Man 007 at approximately 11:4 asident #2 was prescribed outh at bedtime for ia. Review of a medical | e n O | | | |
| | consult for hyperchic hypertension dated 2007 at approximat recommendation to | plesterolemia and September 5, 2006 on Ma sly 11:45 AM revealed a r Resident #2 to return to the 5, 2006. There was no | | | | |
| | documented eviden to the clinic as reco | ce that the resident returnenmended. | | Client # 2 had refused to return to the clinic as echan | dulad A Partico | i |
| | 1, 2007 on May 3, 2 AM revealed that Re Norvase 10 mg and every day for hypert cardiology consult d May 3, 2007 at appr | ysician's orders dated Mar 007 at approximately 11:40 esident #2 was prescribed Maxide 25 mg by mouth ension, Review of a ated November 21, 2006 o oximately 11:50 AM reveal | 1395 1, 2, 3 and 4 | Client # 2 had refused to return to the clinic as sche Missed Appointment Form has been developed. I Manager has been instructed to forward this form with DON and reschedule the appointment. A record to the Primary Care Physician and Case Manager with consumer's records. The consumer's individual right to accept and refuse treatment and services with incorporated into their records i.e. Guardianship do Psychological Assessments etc. QA will monitor to compliance on a monthly basis for the next six mor quarterly thereafter. | te Rouse rith (48) hours to l of antification ill be placed with l ability and legal li be cuments, ISP, ensure | 5/31/2005 and ongoing |
| | a recommendation i | or Resident #2 to return to | | | | |

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If continuation sheet 8 of 10

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MEALIN RESULATION ADMIN

MULAINIA

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| Health R | equiation Administra | ation | | | | , , , , , , , , , , , , , , , , , , , | |
|--------------------------|---|---|---|--------------------------|--|---|-----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER: | A. BUILDIN | PLE CONSTRUCTIC N | (X3) DATE SURVEY COMPLETED | |
| | _ | HED12-0037 | , | B. WING _ | * | 05/03 | /2007 |
| NAME OF P | ROVIDER OR SUPPLIER | | | H | STATE, ZIP CODE | · · · · · · · · · · · · · · · · · · · | |
| SYMBRA | iL. | ¥ | 133 HAMI WASHING | LTON ST, N ITON, DC 2 | VV. 001/1, | *L | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FLEEL S | PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH COF RECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 1 395 | Continued From pa | ige B | | 1.395 | | | |
| | There was no docu resident returned to | nonths (February, 20) Imented evidence the o the clinic as recomm | at the mended. | | | | · . |
| | consult dated Dece 2007 at approxima recommendation to examination. There evidence that the | ech and hearing screenber 21, 2006 on M tely 4:50 PM revealed or Resident #2 have a was no documenter esident had or was s | ay 3, d a an ENT i cheduled | | | 2012 14 | |
| | 4. Review of a speconsult dated Dece 2007 at approxima recommendation for Assessment. There evidence that the | emination as recom- ech and hearing screember 21, 2006 on M tely 5:00 PM reveale or Resident #2 have was no documente esident had or was a ssessment as recom | ening lay 3, d a an Aural d chedulad | | | | |
| L401 | 3520.3 PROFESSI PROVISIONS | ON SERVICES: GEI | NERAL | 1401 | | | |
| | and evaluation, inc developmental level services, and services | es shall include both luding identification of the shall be shall | of nent vent | | Client # 1 was seen by PCP on 3/29/200 physical. He is scheduled to see the PCI Director of Nursing will ensure that proorders are completed for each new admithe Primary Care Physician. QA will be each new admission to ensure complian reviewed new admission on a quarterly | on 6/5/07. per admission ittance by informed of ce and will | 6/15/2007 and ongoing |
| | Based on staff inte facility falled to will notes and a nursin diagnosis and eval | met as evidenced by rview, and record review and record revie admission orders, grassessment that in uations for one of twittingle. (Resident #1) | view the admission cluded | Part Table | A nurse assessment has been completed #1. The Residential Director will prior DON of all new admissions before according to the complete a Nursing Assessment (5) business days of admission and report within consumer's records. A conformated to the CEO and the Reside Director. QA will be informed of each | notice to the ceptance. nent within d a place copy will be nitial new | 6/15/2007 and ongoing |
| - 1 | The findings include | | ng di ang | .9 | admission to ensure compliance and very new admission on a quarterly basis. | vill reviewed | * / |
| | 1. Interview with th | e House Manager or | 1 мау 3, | <u> </u> | <u></u> | | <u></u> |

Health Regulation Administration STATE FORM

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| Health R | egulation Administra | ation | | | | T | |
|--------------------------|---|---|---|-------------------------|---|--|-----------------------------|
| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM | R/CLIA MBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | HFD12-0037 | | B. WING | | 05/03 | /2007 |
| NAME: OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | , , , | |
| SYMBRA | iL | 5 | | LTON ST. N TON, DC 2 | 0011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION SHO (EACH COF RECTIVE ACTION SHO CROSS REFERENCED TO THE APPL DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 1 395 | Continued From pa | ige 8 | | 1 395 | | | |
| | There was no docu | nonths (February, 200 Imented evidence the o the clinic as recomm | at the | r | * | ! 8. | |
| ^ ·- | consult dated Dece 2007 at approxima recommendation for | eech and hearing screember 21, 2006 on M tely 4:50 PM revealed or Resident #2 have a | ay 3, da an ENT | | | \$. | |
| | evidence that the r to have an ENT ex | was no documented esident had or was so amination as recomm | cheduled mended. |) | ; # # | | |
| | consult dated Decc 2007 at approxima recommendation for Assessment. There evidence that the r | ech and hearing screenber 21, 2006 on Mately 5:00 PM revealed or Resident #2 have a was no documented esident had or was seessment as recomposed. | ay 3, d a an Aural d cheduled | | | | |
| 1.401 | 3520 3 PROFESS PROVISIONS | ON SERVICES: GEI | NERAL | 1 401 | | | |
| | and evaluation, inc developmental levi services, and servi | es shall include both luding identification o els and needs, treatm ices designed to prev ther loss of function b | of nent: rent | | Client # 1 was seen by PCP on 3/29/200 physical. He is scheduled to see the PCI Director of Nursing will ensure that proporders are completed for each new admithe Primary Care Physician. QA will be each new admission to ensure complian reviewed new admission on a quarterly | P on 6/5/07. per admission ittance by informed of ce and will | 6/15/2007 and ongoing |
| | Based on staff inte facility falled to wri- notes and a nursin diagnosis and eval residents in the sa | met as evidenced by erview, and record revite admission orders, g assessment that in luations for one of two mple. (Resident #1) | view the admission cluded | | A nurse assessment has been complete #1. The Residential Director will prior DON of all new admissions before accorded to the CSO business days of admission and report within consumer's records. A conforwarded to the CEO and the Reside Director. QA will be informed of each | notice to the ceptance, nent within d a place copy will be ntial | 6/15/2007 and ongoing |
| · | The findings included the first the | le; le House Manager on | · May 3, | | admission to ensure compliance and v new admission on a quarterly basis. | vill reviewed | |

Health Regulation Administration

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HEALTH REGULATION ADMIN

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| Health R | egulation Administra | ation | <u> </u> | | <u> </u> | | |
|--------------------------|--|--|---|-------------------------|---|---------------------------------------|--------------------------|
| STATEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | A BUILDING | PLE CONSTRUCTION | (X3) DATE 51 COMPLE | JRVEY TED |
| ; | | HFD12-0037 | | B. WING | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 05/0 | 3/2007 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TATE ZIP CODE | 100 T | * |
| SYMBRA | • | | | TON ST, N TON, DC 20 | 0011 | · | , |
| (X4) ID PREFIX TAG | VEACH DESIGNENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORM | / FULL 1 | PREFIX TAG | PROVIDER'S PLAN OF CO (EACH COF RECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE |
| 1 401 | Continued From pa | ige 9 | | 140# | <u>.</u> | | |
| | Resident #1 was a February 3, 2007 at revealed that Resident #1 documented evide admission orders the was admitted to [Note: Resident #1 2. Interview with the 2007 at approxima Resident #1 was a February 3, 2007 at approxima Resident #1 was a February 3, 2007 at approximated evident #1 was a february 3, 2007 at approximated #1 was a february 4, 2007 at approximated #1 was a february 4, 2007 at approximated #1 was a february 4, 2007 at approximate | is not on medication a House Manager or itely 11:00AM reveal dmitted to the facility Review of medical r proximately 11:30AM idence that a nursing | on al records AM to the no n write #1 when May 3, ed that on ecords on | | | | |
| | | *** | | | | _ | 900 |
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If continuation sheet 40 of 10.

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| Health F | <u>Regulation Administra</u> | tion | <u> </u> | | <u> </u> | - CIMPI | MFF.NOVED. | |
|-----------------------------|--|--|--------------------|----------------------------------|--|---|--------------------------|--|
| | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM | | A BUILDI | IPLE CONSTRUCTION , | (XS) DATE 9 COMPLE | | |
| | <u> </u> | HFD12-0037 | 3 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | | |
| SYMBRA | L | | 133 HAM WASHING | MILTON ST, NW NGTON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) | | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE | |
| l 206 | Continued From page 3 acknowledged that the two health certifications were not available during the survey. Staff (****) | | | 1 206 | The two employees current health record personnel. (Staff the health record date and the health record date is 5/4/2007) will ensure that all employee files are commencement of employment available review periods. QA will review | is 1/2/2007 Dersonnel Impleted and made | 5/10/2007 | |
| 1227 | 3510.5(d) STAFF T | | 4.:2 | 1 227 | employee files on a quarterly basis to en compliance. | isure | | |
| T, "." | limited to the follow | _ | | | 1. Staff : has completed CPR tra 1/16/2007. All staff have CPR Pers ensure that staff complete training. | ining on onnel will | 5/04/2007 | |
|] | (c) Infection control | for staff and resident | \$; | , | Single man sum complete training. | | | |
| | Based on record re- effectively train staff | met as evidenced by: view, the facility failed f to implement emerg the clients in the facili | to ency | | QA will review employee files on a basis to ensure compliance. | quarterly | . ,, | |
| | The finding includes | S C | | | | , | | |
| | 2007 at approximate documented eviden | r) certifications for one | no | | | · | | |
| | 3510.5(f) STAFF TF | - | · | 1 229 | · | | | |
| | limited to, the follow | - | , | ; , · | | , | | |
| | residents to be serve to, behavior manage | elated to the GHMRP ed including, but not le ement, sexuality, nutri nmunications, and as | imited ition, | | | | e. | |
| | Based on interview a failed to falled to en- received annual train | net as evidenced by: and record review, the sure that each employ ning in sexuality and r | /ee | | | | | |
| Annal Marie To State of the | flow Arientale implement | | | - 4 | <u>, 2 , 3 , 3 , 7 , 7 , 7 , 7 , 7 , 7 , 7 , 7</u> | | <u> </u> | |